THE FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM: A MODEL FOR WORKERS, NOT MEDICARE

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EXECUTIVE SUMMARY

The Federal Employees Health Benefits Program (FEHBP) works well in providing decent, affordable health coverage for the 8.5 million people it serves, including the president, members of Congress, federal employees, retirees, and their families. The most tangible real-world example of "managed competition," FEHBP is a system of competing private health plans in which the government contributes a relatively fixed amount toward the employee's coverage and employees pay a premium based on the cost of the individual plan they choose.

Largely because of its ability to constrain cost growth reasonably well with limited government intervention, the program has been proposed by some political leaders and analysts as a model to replace the current Medicare program, to cover small businesses and the uninsured, or, in some cases, to cover the entire nation. This analysis finds that FEHBP would represent a substantial improvement over the high premiums and limited benefits currently faced by small businesses and uninsured adults. The approach would not work well, however, for the older, sicker populations served by Medicare. Not only is the FEHBP model likely to lead to discrimination against ill or disabled beneficiaries, but Medicare's large-group purchasing clout would be diminished, program administrative costs would rise, and, as a result, costs to government and beneficiaries alike would grow. While FEHBP insures retirees, this coverage is largely supplemental to Medicare and thus does not bear the full risk of health services for an elderly, less healthy population.

This report describes FEHBP and how it has worked over the years, examines how it might work if applied to Medicare or small businesses and the uninsured, and assesses whether the model would be an improvement over current systems of health coverage.

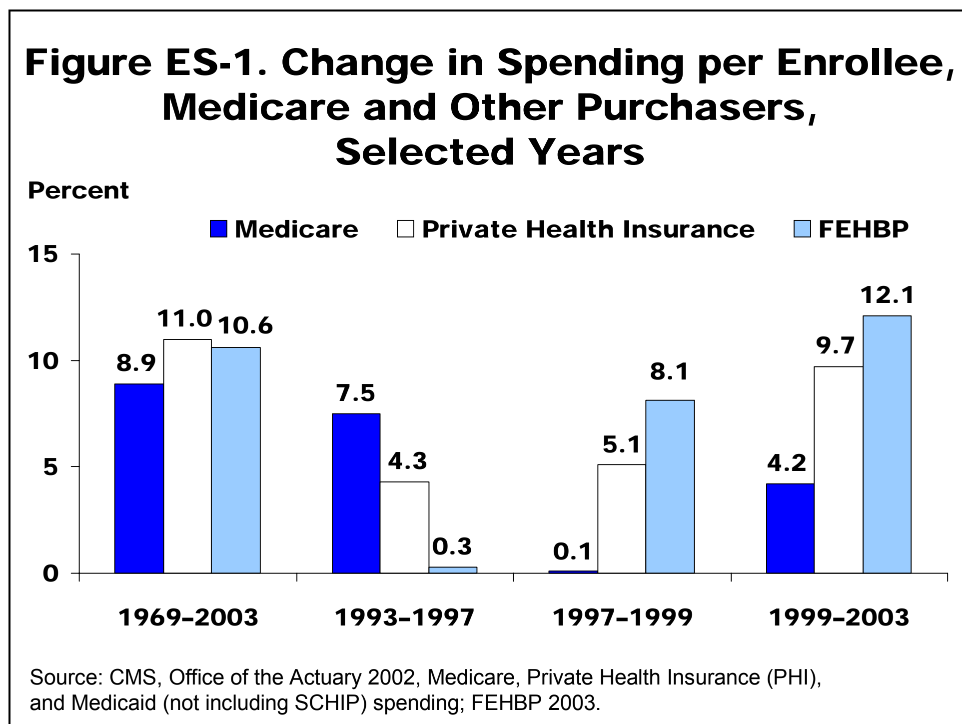
Overview of FEHBP

Enrollment and plan participation. The largest employer health insurance program in the United States, FEHBP insures about 3 percent of all Americans. As of 2003, 133 plans, offering 188 coverage options, are participating in FEHBP. One dozen of these options are offered by nationwide preferred provider organization (PPO)/fee-for-service plans; six of these nationwide plans are available to specific groups of federal employees (e.g., Foreign Service); and the remaining plans are local HMOs. Enrollment, however, is concentrated in just a few plans: over half the enrollees are enrolled in Blue Cross Blue Shield and another quarter are in one of the other national PPO/fee-for-service plans.

Government contribution and benefits. The government's contribution toward the cost of the beneficiary's premium is the lesser of 72 percent of the average FEHBP plan premium, weighted by enrollment, or 75 percent of the premium for the plan chosen. The enrollee pays the difference. There is no standard prescribed minimum benefit package, and benefits vary from plan to plan. In general, the benefits offered by large employer plans are richer than those in FEHBP; benefits in Medicare, meanwhile, are not as generous, principally due to that program's lack of prescription drug benefits and catastrophic coverage.

Premium-setting. Most PPO/fee-for-service FEHBP plans are experience-rated; premiums are based on expected costs, plus a small service charge. Plans are not strictly at risk and can recover losses either through tapping into reserve funds or increasing the premium in a subsequent year. HMOs are community-rated, charging rates comparable to those charged to nonfederal groups.

Cost history. Since 1969, FEHBP has experienced slightly lower premium growth per enrollee than private health insurance overall (10.6% vs. 11.0%) but higher growth than Medicare (8.9%) (Figure ES-1). In the last four years, Medicare has outperformed FEHBP by a far greater margin, with premiums growing at only about one-third the FEHBP rate. In addition, Medicare's administrative costs as a percentage of total claims cost have been far lower than FEHBP's (2% vs. 7%–15%).



Risk selection and plan participation. Throughout its history, FEHBP has suffered from adverse risk selection, which occurs when sicker beneficiaries gravitate toward certain plans. Indeed, the program nearly lost Blue Cross Blue Shield in the early 1980s as a result of adverse selection. Although more than 84 percent of retirees choose PPO/fee-for-service plans, FEHBP does not employ risk adjustment of any kind to account for differences in enrollees' health; consequently, HMOs benefit from a younger and therefore healthier enrollment. Some HMOs nevertheless have experienced enrollment so low that they have had to withdraw from the program. Unstable plan participation has been a problem for FEHBP, as it has for the Medicare+Choice program. Insufficient enrollment or unpredictable health care utilization led to more than 100 FEHBP plan withdrawals between 2000 and 2002.

Converting Medicare to the FEHBP Model

Proposals to convert Medicare to the FEHBP model would require either that basic, fee-for-service Medicare compete on the same basis as private health plans or that the program move entirely to a system of competing private plans. Most proposals would have the government provide a fixed dollar amount based on a percentage of the average plan premium (e.g., 85%). Under this "defined contribution" approach, beneficiaries would pay the difference between the premium of the plan selected and the government's contribution. Proponents say that government costs would be reduced, government involvement minimized, and plan choice enhanced. Our analysis finds, however, that the FEHBP model poses serious risks to Medicare beneficiaries as well as taxpayers.

Costs. As a single, large governmental purchaser of care, Medicare achieves lower administrative costs and lower provider payment rates than private plans do. To date, private plans have not demonstrated a value-added advantage over Medicare's inherent cost-savings advantages. It may be possible for the federal government to reduce its financial exposure under a FEHBP approach by reducing its share of the premium, changing the "benchmark" plan to one whose price is lower than average, or reducing the benefit package. Unless these changes are draconian, however, these changes may not compensate for the more favorable payment rates Medicare now enjoys and the much lower growth rates that result. The government may also save money if competition results in enrollees choosing lower-priced plans. But, again, the savings FEHBP achieves through competition have not been greater than savings from Medicare's system. Moreover, if the choice of lower-priced plans is not accompanied by an adequate risk-adjustment mechanism and plans do not fully assume risk (neither of which has occurred), any resulting savings may be illusory.

Unless competition succeeds in lowering overall cost growth substantially, all the other measures to increase savings to the government will simply increase costs to the beneficiary. A lower government share of the premium or reduced benefit package will have to be made up by higher beneficiary spending. Medicare currently pays only 57 percent of the total health expenses of beneficiaries. Any further reductions in that share will be felt by most beneficiaries, but especially by the sicker and more disabled individuals who are heavy users of health services.

Choices and complexity. Increasing the number of plan choices carries with it a greater risk of confusion for Medicare beneficiaries. Four million elderly beneficiaries have Alzheimer's disease; 2 million are in nursing homes, many with cognitive impairments, and 12 million have less than a high school education.

Risk selection. The average FEHBP enrollee is 46 years old and in good health. On the other hand, one-third of Medicare enrollees have serious physical or cognitive impairments, accounting for two-thirds of Medicare outlays. These skewed expenditures create a strong incentive for private plans to market to younger, healthier enrollees, causing premiums in traditional Medicare to spiral upward. Given that HMOs in FEHBP and in Medicare have experienced favorable selection to date, an expansion of private plan participation in Medicare is likely to have a similar result.

Plan stability. Both Medicare and FEHBP have suffered from instability in private plan participation. For older, sicker Medicare beneficiaries, the potential disruption in care from plan withdrawals or instability in plan provider networks is particularly worrisome.

Government intervention. Although FEHBP has operated with little government intervention, its spending is only about one-tenth that of the Medicare program. It seems unlikely that government policymakers will remain immune from plan and provider pressure if the stakes are raised to Medicare's level.

Using FEHBP to Cover Small Businesses and the Uninsured

Proposals to extend FEHBP to small businesses and the uninsured are based on the following assumptions: that large group pooling would result in lower premiums for small businesses and individuals than they can obtain on their own; that benefits would be improved; and that coverage would become available for persons currently ineligible due to prior health problems. The likely effects of extending FEHBP to these groups are summarized below.

Costs and access. FEHBP has much lower administrative costs than the small group and individual insurance markets, where they can range from 20 to 50 percent. The large group pooling that FEHBP offers could also lower premiums, unless only sicker individuals and higher-risk businesses opt for such coverage. Premium assistance or tax credits may be needed to ensure that healthy people also enroll. No one would be prohibited from enrolling on the basis of poor health.

Plan choices. FEHBP's wide array of plan choices and provider networks is significantly greater than that offered to individuals and small businesses. Some plans, however, may be unwilling to participate due to the broadening of government involvement in health coverage. Providing federally subsidized reinsurance and risk-adjustment may help reduce the risk to plans and make participation more palatable.

Administrative complexity. Administering a program for 44 million uninsured people across the country is far more complex than doing so for 8.5 million federal employees and retirees who are geographically more concentrated.

Conclusion

If extended to Medicare, the FEHBP model poses serious risks to Medicare beneficiaries and likely risks to the taxpayer as well. It would provide no significant, demonstrable improvement in the current system while opening the door to increased financial risk for enrollees. If applied to small businesses and the uninsured, however, the FEHBP model has certain tangible advantages: the promise of lower premiums, better benefits, greater choice, and more stable coverage than what is currently available.

THE FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM: A MODEL FOR WORKERS, NOT MEDICARE

INTRODUCTION

The Federal Employees Health Benefits Program (FEHBP) is increasingly held up as a model for providing health insurance coverage to Medicare beneficiaries, the uninsured, and the entire U.S. population. As the most tangible working example of "managed competition,"[1] the program relies on competing private insurers to provide numerous coverage options—188 in total—for its enrollees. Proponents of expanding the FEHBP model say that in addition to offering a variety of benefit packages and provider networks that can meet employees' different needs, it can also produce savings by encouraging enrollees to select more efficient, lower-cost plans.[2] With the government contributing a fixed dollar amount toward coverage, enrollees pay larger premiums when they choose a higher-cost plan and smaller premiums when they choose a lower-cost alternative.

Much of the debate in Congress over Medicare prescription drug legislation is not just about the design of a drug benefit but about expanding private plan participation in Medicare. The drug benefit would be provided by private plans. Beginning in 2010, the House bill in particular would provide a fixed-dollar contribution toward coverage of all Medicare services, either through private plans or through Medicare's traditional fee-for-service program, with beneficiaries paying the difference in cost.[3] This is sometimes characterized as making Medicare more like FEHBP, although in practice it has substantive differences. For example, PPO plans in FEHBP are not strictly at risk; in most Medicare reform proposals, however, private plans would bear risk and have stronger incentives to reduce costs and benefits.

Several presidential candidates have also proposed letting small businesses, the self-employed, and individuals without access to group coverage purchase health insurance through a FEHBP-like model.[4] Often referred to as the Congressional Health Plan, it would give the uninsured and employees of small firms access to the same coverage available to members of Congress. Some political leaders and policy experts have gone a

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[1] A. C. Enthoven, "Effective Management of Competition in the FEHBP," *Health Affairs* 8 (Fall 1989): 33–50.

[2] T. N. Ballard, "Higher Premiums, Fewer Health Plans to Choose From During Open Season," *Government Executive Magazine* (Nov. 8, 2002). Available at http://www.govexec.com/dailyfed/1102/110802t1.htm.

[3] Health Policy Alternatives, Inc., *Prescription Drug Coverage for Medicare Beneficiaries: Side-by-Side Comparison of S1 and HR1* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, July 2003).

[4] S. R. Collins, K. Davis, and J. Lambrew, *Health Care Reform Returns to the National Agenda: The 2004 Presidential Candidates' Proposals* (New York: The Commonwealth Fund, Sept. 2003).

step further: they have suggested that the entire U.S. population be enrolled in FEHBP, effectively creating a health insurance system of competing private plans.[5]

This report summarizes the history of FEHBP and examines how well the program has served the federal workforce and its retirees. It then analyzes the advantages and disadvantages of applying this model to Medicare beneficiaries and to uninsured individuals and employees of small businesses. In particular, it raises concerns about the dangers of adverse risk selection—which occurs when sicker beneficiaries gravitate toward certain plans—that are inherent in any system of competing private health plans, especially one that would cover vulnerable, high-risk populations. A program that works reasonably well for 8.5 million federal workers and their family members might not work quite the same if expanded to cover 40 million Medicare beneficiaries, who are considerably sicker and more disabled, or 44 million uninsured, most of whom are healthy and work but frequently experience changes in employment or insurance status.

ASSESSING THE FEHBP EXPERIENCE

Before turning to how FEHBP might work for nonfederal employees, it is instructive to distinguish between the program as it has worked in practice from an idealized managed competition model. FEHBP has strengths and weaknesses, like any system of insurance. Since 1960, it has given federal employees and retirees a multitude of health plan choices while providing participants with incentives to select the most cost-efficient plans.[6] Administered by the Office of Personnel Management (OPM), FEHBP is a primary example of competition among market-based private insurance plans.

Enrollment

The largest employer health insurance program in the United States, FEHBP covers an estimated 8.5 million people, including federal employees, retirees, and their dependents. Of the 4.1 million employee participants, 2.2 million are active employees and 1.85 million are retired. About 85 percent of all federal employees are enrolled.[7] There are two groups of retirees: those who are age 65 or over (83%),[8] the vast majority of whom have Medicare as their primary coverage, and those who are retired but are not yet eligible for Medicare, who are the most costly group of enrollees since FEHBP typically is their sole

[5] J. Breaux, "The Breaux Plan: A Radically Centrist Approach to a New Health Care System," *BCA Today* (Jan. 23, 2003), available at http://www.bcatoday.org/clientdoc/breaux.pdf; G. R. Wilensky, "Thinking Outside the Box: A Conversation with John Breaux," *Health Affairs* Web Exclusive (Mar. 5, 2003): W3-124–W3-130.

[6] Office of Personnel Management (OPM), *FEHB Handbook,* Cost of Insurance, Shared Cost. Available at http://www.opm.gov/insure/handbook/fehb03.asp.

[7] OPM, http://www.opm.gov.

[8] Enthoven, "Effective Management," 1989.

source of coverage. Perhaps the biggest advantage the program offers federal employees and retirees is the security of knowing that they will always be protected from high out-of-pocket health care costs.

FEHBP enrollees differ from a typical cross-section of Americans in a number of respects. Geographically, they are more concentrated in the Washington, D.C., area—more than one-tenth of active employees are in the D.C. area—although there are federal employees throughout the country. They are also less likely to have low incomes, given their federal employment history. And while FEHBP insures retirees, this coverage is largely supplemental to Medicare and thus does not bear the full risk of health services for an elderly, less healthy population.

It should be remembered that while the federal government is the largest single employer in the United States, it covers less than 3 percent of all Americans. That is a relatively small base on which to build, and extrapolating the program's experience to other populations may not yield comparable results.

Federal Premium Share and Benefits

Since 1999, the maximum government premium contribution has been the lesser of: (a) 72 percent of the average premium, weighted by enrollment, of all participating plans; or (b) 75 percent of the premium for the plan selected.[9] This means that even in a low-cost premium plan, one that would be completely covered by the maximum government contribution, the enrollee is still responsible for paying 25 percent of the premium. If enrollees select a plan with an above-average premium, they pay 28 percent of the average plan premium plus all of the difference between the premium of the plan they select and the average premium. This gives employees a powerful incentive to enroll in lower-cost plans.

There is no standard prescribed minimum benefit package mandated for FEHBP plans. Instead, benefits vary from plan to plan. In recent years, for experience-rated plans, OPM has purchased the higher of current benefits or the highest level of coverage offered to employer groups by the plan. For community-rated plans, OPM purchases the community benefit package that covers the majority of the plan's subscribers, with adjustments for specific OPM requirements. On occasion, OPM requests particular benefit changes from all plans,[10] but, overall, plans are left to develop their own benefit packages. Given the differences in benefit packages across plans, a lower-cost plan may be one with fewer benefits or higher deductibles, rather than necessarily a "more efficient" plan.

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[9] OPM, *FEHB Handbook*. Available at http://www.opm.gov/insure/handbook/fehb00.asp.

[10] M. Merlis, *The Federal Employees Health Benefits Program: Program Design and Recent Performance* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, May 2003).

In general, benefit packages provide comprehensive coverage for the following: hospital, medical, surgical, diagnostic, mental health, preventive, maternity, and emergency care; prescription drugs; chemotherapy and radiation therapy; physical and rehabilitation therapy; renal dialysis after kidney failure; nursing care after an illness; cosmetic or oral surgery after accidental injury; and dental care. Some participating insurers offer both a high-option and a standard benefit package, with lower cost-sharing in the high-option plan. Other plans may have standard and basic plans with different restrictions placed on out-of-network, nonemergency services. For example, the plan with the largest enrollment (Blue Cross Blue Shield's standard option) includes a deductible of $250 per individual or $500 per family, $15 copay for network physician visits, and 25 percent cost-sharing at network pharmacies. It covers comprehensive inpatient and ambulatory services, with a ceiling of $4,000 on out-of-pocket beneficiary costs for in-network covered services.[11] To hold the line on premium increases, OPM in recent years has prohibited improvements to the benefit package unless they are offset by reduced benefits in other areas.[12]

FEHBP benefits are somewhat less generous than those offered by large private employers. A 1998 study by the Congressional Budget Office that compared federal benefits with those of large private firms found that the value of the FEHBP benefit package was less than that of private firms, principally because of the difference in the employer contribution toward the premium. For a 35-year-old employee, the private benefit package was worth about 23 percent more than the Blue Cross Blue Shield FEHBP package.[13]

On the other hand, FEHBP's benefits are more generous than Medicare's. All FEHBP plans cover prescription drugs. According to one estimate, the value of Medicare's basic benefits is 12.8 percent lower than those offered by the most common plan in FEHBP, and 28.8 percent lower when considering all benefits, including prescription drugs. In 2003, Medicare benefits have an estimated value of $6,570. "Upgrading" these benefits to the standard-option Blue Cross Blue Shield FEHBP plan, which includes prescription drug coverage, would raise their cost to $8,460.[14]

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[11] OPM, *FEHB Handbook*. Available at http://www.opm.gov/insure/handbook/fehb00.asp.

[12] Merlis, *Federal Employees,* 2003.

[13] Congressional Budget Office, *Comparing Federal Employee Benefits with Those in the Private Sector* (Washington, D.C.: CBO, Aug. 1998).

[14] C. L. Peterson, *Comparison of Actuarial Values: Current Medicare Benefits to a "Typical" Health Plan Available to Federal Employees* (Washington, D.C.: Congressional Research Service, Mar. 31, 2003).

Plan Participation

There were 188 health plan coverage options offered by 133 plans in 2003. One dozen options, open to all federal employees, are offered by nationwide preferred provider organization (PPO)/fee-for-service plans; of these, four PPOs and two fee-for-service plans without PPO networks are available to selected groups of federal employees, such as members of the Foreign Service and Secret Service, and the remainder are provided by local health maintenance organizations (HMOs) offered only to those employees residing in specific geographic service areas served by those HMOs.[15] FEHBP negotiates with private health insurance carriers to purchase plans, and the plans pay for all medical services. FEHBP does not itself make any payments to plan participants.

The dominant plan, Blue Cross Blue Shield, includes both a standard and basic option, both of which are PPO/fee-for-service models. About half of all FEHBP enrollees participate in these plans.[16] The standard option covers payment to any health care provider but offers reduced beneficiary cost-sharing if services are received through PPO network providers. In the basic plan, all nonemergency services are covered exclusively through PPO providers. The majority of the other national plans offer a PPO feature, with lower cost-sharing when patients see in-network providers. One plan, for the American Postal Workers Union, now offers a "consumer-driven" option.[17]

While FEHBP includes multiple plans, most enrollees are concentrated in a few plans. About half of all enrollees participate in the Blue Cross Blue Shield PPO options; another quarter are enrolled in largely PPO or fee-for-service employee organization plans.[18] Only about one-quarter of employees are enrolled in HMO plan offerings (Figure 1). Retirees are more likely to enroll in Blue Cross Blue Shield or other national PPO plans, while active workers and dependents are more likely than retirees to enroll in HMO plans. For example, 84 percent of retirees are in PPOs compared with 62 percent of active employees.

The number and type of plans available in any given geographic market vary significantly. While it is always possible to enroll either in one of the national plans available to all federal employees or in one of the national PPO plans run by employee

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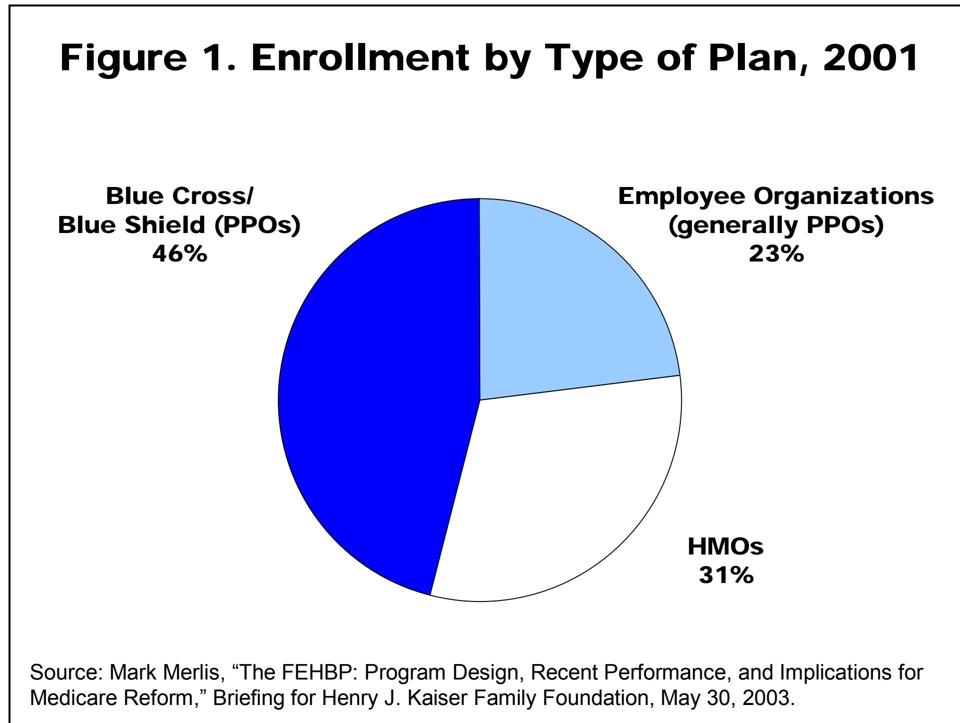
[15] Statement of Abby L. Block, Senior Advisor for Employee and Family Policy, U.S. Office of Personnel Management, Before the Committee on Finance, U.S. Senate, April 3, 2003.

[16] Center for Medicare Advocacy, Inc., 2003. Available at http://www.medicareadvocacy.org.

[17] Under this plan, an individual enrollee is given $1,000 as part of a personal care account, the unused portion of which may be carried over in the next calendar year. If an employee's health care costs exceed the $1,000, the enrollee pays 100% of all costs up to $600. Plan coverage, subject to coinsurance requirements, starts at the point at which the employee's expenses exceed $1,600. For families the amount allotted is $2,000, with traditional coverage starting after costs exceed $3,200.

[18] Merlis, *Federal Employees,* 2003.

organizations, some geographic areas may have very few or no HMOs. This is a reflection of both the historical development of managed care plans and the particular way FEHBP sets local premiums for HMOS and national premiums for PPOs. Only 41 states have any participating HMOs.



Structure, Financing, and Premiums

OPM uses two methods to establish premiums. Most PPOs, including the national Blue Cross Blue Shield plan, are experience-rated, while most HMOs are community-rated.

- *Experience rating:* Premiums are computed as the individual plan's projected health care and administrative costs plus a "service charge" of from –0.23 percent to 1.1 percent.[19] The projected cost is calculated by looking at the plan's cost experience with the FEHBP group, adjusted for inflation, benefit changes, and other factors. Because of the somewhat subjective nature of this calculation, it becomes an item for negotiation between OPM and the plan. Experience rating was used by all the PPO plans and 20 of the HMOs in 2003.[20]
- *Community rating:* The community-rated premium is at least comparable to the lower of the rates that the plan charges two nonfederal employer groups in the

[19] It is doubtful that a plan would remain in the program if it were facing a negative charge, nor is it likely that a plan would receive the full 1.1%.

[20] Merlis, *Federal Employees,* 2003.

region. The community rate is adjusted to reflect differences between the FEHBP benefit package and the package on which the rate was built. The rate may also be adjusted for the demographics of the FEHBP group.

Regardless of the method by which premiums are set, the agreed-upon rates are increased by 1 percent for OPM administration and 3 percent for the plan's contingency reserve, which is held in plan-specific accounts within trust funds. Plans have access to these reserves, subject to OPM approval, if the level is above the preferred minimum balance. Experience-rated plans have access to the reserves if their actual claims exceed what was assumed in their premium; community-rated plans have access to the reserve if their final community rate is higher than the preliminary rate on which their premium is based.

It is important to note that the PPO plans, representing more than three-quarters of enrollment, are not strictly risk-bearing plans. As currently structured, they can recover losses either by tapping into reserve funds or by increasing the premium for a subsequent year. Since the "service charge" paid to the plan is based on plan benefit and administrative costs, the plan's actual profit grows as claims costs grow.

HMO premiums are based on rates charged to large employers. They include a built-in profit rate of return similar to that achieved in their commercial large-employer business. Total overhead on HMO contracts averages 10 to 15 percent.

Each federal agency provides its active workers with a contribution toward coverage. Employees then pay the remainder of the premium themselves. The government's share of retiree premiums is met through OPM budgetary outlays. OPM administrative costs are covered by the add-ons to plan premiums. Two trust funds collect premiums, one for employees and one for retirees. The two funds disburse premiums to health plans and shift necessary amounts for administration to OPM.

The federal administrative costs of FEHBP are quite low, although the administrative costs of participating health plans are comparable to those of large private employer plans. OPM itself incurs administrative expenses of less than one-tenth of the 1 percent add-on to plan premiums. Each federal agency administers the enrollment of its own employees, and those costs are not included in OPM administrative expenses. PPOs' average administrative costs are 7 percent—somewhat high given that they are essentially cost-plus-experience-rated plans. Average administrative costs for HMOs are 10 to 15

percent, comparable to those of Medicare+Choice plans and large-employer HMO plans[21] but higher than the 2 percent for traditional Medicare.

COST PERFORMANCE OVER TIME

Over the period 1969–2003 (the time frame for which comparable data are available), FEHBP premiums have increased at an annual rate of 10.6 percent. While this track record is not as good as Medicare's, which experienced 8.9 percent annual increases in expenditures per enrollee, it is better than the 11.0 percent annual increase in private health insurance premiums (Table 1). A small portion of Medicare's slower growth can be attributed to Medicare's lack of a prescription drug benefit. It should be noted that comparison of premiums in FEHBP with those charged by other employers and Medicare is complicated by differences in benefit packages. In addition, small businesses typically experience more rapid increases in premiums than larger businesses do, so comparison between FEHBP and private employers depends on whether all firms or only large private firms are included in the comparison.

Table 1. FEHBP and Private and Medicare Premiums per Enrollee, CY 1970–2003[1,2] (average annual growth rates by period)

Calendar Years	Medicare	Private Health Insurance	FEHBP	Medicare Excluding Rx	Private Health Insurance Excluding Rx	FEHBP Excluding Rx[3]
1969–2003	8.9%	11.0%	10.6%	8.9%	10.6%	10.2%
1985–1991	7.0	10.8	11.7	6.9	10.7	11.6
1991–1993	8.6	8.7	8.4	8.6	8.6	8.3
1993–1997	7.5	4.3	0.3	7.4	3.1	–0.7
1969–1997	10.3	11.6	10.6	10.3	11.4	10.3
1997–1999	0.1	5.1	8.1	–0.1	3.6	6.4
1999–2003	4.2	9.7	12.1	4.2	8.8	11.1

[1] Per enrollee growth rates are based upon calendar year FEHBP and private health insurance premiums, and upon calendar year Medicare total (benefits and administrative costs) expenditures.

[2] Total FEHBP covered lives are estimated by the Office of Personnel Management.

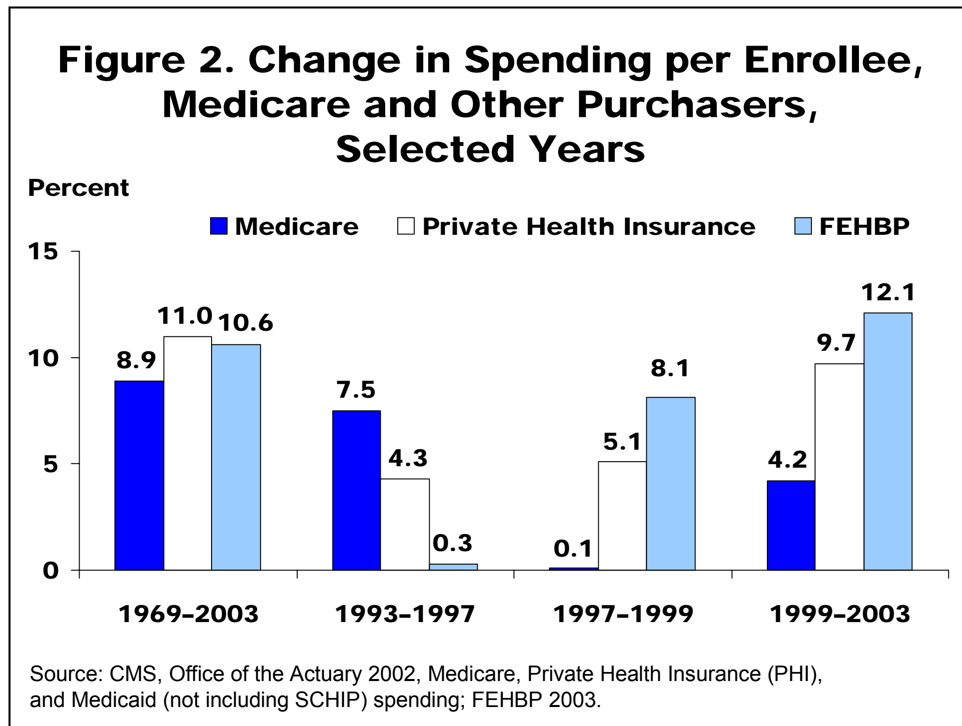
[3] The estimate of FEHBP excluding prescription drug spending was calculated by applying the share that prescription drugs were of overall private health insurance premiums to FEHBP premiums.

Notes: 2002–2003 data are projected for Medicare and Private Health Insurance. FEHBP data are actual reported data. Because 2003 enrollment by plans is not yet available, 2002 enrollment for each plan within FEHBP is used to estimate aggregate premiums and to create subsequent per enrollee premiums. Enrollment in plans that dropped out between 2002 and 2003 are not included in the enrollment estimates. FEHBP estimates of enrollment and premiums for 1980 did not include low options plans causing the estimates to be inconsistent with other years.

Source: CMS/Office of the Actuary. FEHBP data from the Office of Personnel Management.

[21] Ibid.

Medicare spending has increased at a particularly low rate ever since the Balanced Budget Act of 1997 curtailed provider payment rates. In the last three years, FEHBP expenses per enrollee have exceeded those of private insurers (12.1% vs. 9.7%), which in turn have considerably exceeded Medicare's (4.2%)[22,23] (Figure 2). Some of the differences in growth rates, however, may occur because of differences in benefit packages and because of differences in underlying cost and health trends for different population groups.



Interestingly, since 1997 FEHBP premiums have been about one percentage point a year lower than they otherwise might have been as a result of enrollees switching from higher-cost plans to lower-cost ones.[24] Although only 5 percent of enrollees typically change plans in a year,[25] switchers do help lower the cost of FEHBP to the federal government as well as to themselves. As shown in Table 2, premiums in 2003 would have been 1.2 percentage points higher without these changes in health plan. It should be noted, however, that between 2001 and 2003, benefit reductions lowered premiums more than enrollee switching.

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[22] Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.

[23] FEHBP has announced that for 2004, their premium increases have been held to 10.6%. See www.opm.gov/pressrel/2003/

[24] OPM, http://www.opm.gov.

[25] GAO, *Federal Employees', OPM's Role,* 2002.

Table 2. Components of FEHBP Premium Changes in 2003

Utilization, technology, and medical inflation	8.1%
Increased drug costs	3.5%
Demographics (age, sex, etc.)	1.0%
Other (reserves, financing, etc.)	0.3%
Benefit changes	–0.6%
Enrollee choice (plan movement)	–1.2%
Total Change	**11.1%**

Source: Office of Personnel Management, 2003.

Furthermore, some plan switching may be a geographic phenomenon rather than a movement toward "more efficient" plans. PPO premium rates are set nationally, while HMO rates are set locally. As a result, in areas where health care costs are high, local HMOs will be more expensive; in areas where costs are low, national PPO premiums will be more expensive. Switchers may simply be changing plans because of the disparity between national and local costs. In 2002, a FEHBP enrollee residing in Colorado could save $47 per month by switching from standard Blue Cross Blue Shield to PacifiCare. An enrollee in Oregon, however, could save $60 by doing the reverse, since the Blues charge the same premium throughout the country.

Risk Selection

Adverse risk selection has been a serious issue for FEHBP. It nearly killed the program in 1981–82, when Blue Cross—which at the time covered about 45 percent of federal workers, including most of the oldest and sickest—nearly pulled out.[26] In 1985, as a result of risk selection, there was a 68 percent difference between Blue Cross's high-option plan premium and its low-option plan premium.[27] During the 1985–1988 period, spiraling premiums in the high-option plan caused it to lose half its market share in three years.[28] Consequently, Blue Cross eventually withdrew its high-option plan. A 1988 study commissioned by OPM concluded: "The history of FEHBP is a study in the erosion of the group insurance principle by risk selection."[29] Nonetheless, the program has survived, and plans continue to participate.

[26] H. P. Cain, "Moving Medicare to the FEHBP Model, or How to Make an Elephant Fly," *Health Affairs* 18 (July/Aug. 1999): 25–39.

[27] J. Newhouse, "Patients at Risk: Health Reform and Risk Adjustment," *Health Affairs* 13 (Spring 1994): 132–46.

[28] W. P. Welch, "Restructuring the Federal Employees Health Benefits Program: The Private Sector Option," *Inquiry* 26 (Fall 1989): 321–34.

[29] Towers, Perrin, Foster and Crosby, *Study of FEHBP,* OPM, Apr. 22, 1988, p. 2, cited by C. Schoen and L. Zacharias, with G. Santa Anna and S. Kelly, "Federal and State Public Employees Health Benefits Programs," in E. Ginzberg (ed.), *Critical Issues in U.S. Health Reform* (Boulder, Colo.: Westview Press, 1994).

One recent study, by Florence and Thorpe, found no biased selection in FEHBP.[30] The analysis, however, excluded all retirees (including those under age 65) and all individuals choosing family coverage. Moreover, the researchers had no independent information on health risk; they simply used age and sex as proxies. The fact that PPOs have a greater concentration of retirees than HMOs clearly shows that the latter, as a whole, are benefiting from favorable selection. As one indication that the health risk of plan enrollment varies widely, 2003 premiums for a single enrollee in the Washington, D.C., area ranged from $2,749 in Aetna Health standard coverage to $4,178 in CareFirst Blue Choice coverage. Some of this may reflect differences in benefits.[31] But even plans with very comparable benefits, such as Kaiser Mid-Atlantic and CareFirst, can have very different premiums—in this case, $3,204 versus $4,178.[32] Part of the difference may be due to tighter management of care by Kaiser Mid-Atlantic, but some of the difference is also likely to reflect differences in the health status of enrollees.

Another way in which risk selection can manifest itself is in plan withdrawals. If a plan has disproportionately sicker enrollees and is unable to produce an adequate return, it may decide to drop out of the program. Although plan participation in FEHBP has not been studied as extensively as in the Medicare+Choice managed care program, there is evidence showing that FEHBP has also experienced considerable instability in HMO plan participation.[33] In fact, the number of participating plans declined from 276 to 170 between 2000 and 2002 (although some of this decline reflected a merger of two contracts for adjacent areas).[34] The General Accounting Office (GAO) cites as major factors leading to HMO withdrawals insufficient enrollments, unpredictable plan utilization and excessive risk, and noncompetitive premiums.[35] The GAO notes that plan withdrawals represent a market correction; plans with low FEHBP enrollments in areas dominated by large plans conclude they cannot compete effectively.

As in Medicare+Choice, provider participation in plans can also be a problem in FEHBP. Even PPOs may have quite limited provider networks. One study found that of six PPO plans in Lebanon, Kansas, only one (Blue Cross Blue Shield) had any participating physicians within 40 miles or a one-hour drive.[36]

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[30] C. Florence and K. E. Thorpe. "How Does the Employer Contribution for the Federal Employees Health Benefits Program Influence Plan Selection?" *Health Affairs* 22 (Mar./Apr. 2003): 211–18.

[31] Merlis, *Federal Employees,* 2003.

[32] Ibid.

[33] GAO, *Federal Employees' Health Program: Reasons Why HMOs Withdrew in 1999 and 2000* (Washington, D.C.: GAO, May 2000).

[34] GAO, *Federal Employees', OPM's Role,* 2002, p. 7.

[35] GAO, *Federal Employees', Why HMOs Withdrew,* 2000.

[36] Merlis, *Federal Employees,* 2003.

Summary

The FEHBP program has served its enrollees relatively well, providing an array of insurance options and fairly comprehensive benefits. Its premium increases have been more moderate than those of other employer group plans, although higher than Medicare's. Most employees are concentrated in a few PPO plans, including the national Blue Cross Blue Shield standard option plan. Retirees, in particular, prefer the broader networks available in PPOs to the more tightly controlled networks and prior authorization requirement for specialty referrals that are typical of HMOs. The primary disadvantages from the perspective of federal employees are: instability of plan participation, risk segmentation, a relatively high premium share, and a relatively high degree of complexity.[37]

FEHBP departs substantially from the ideal of managed competition. The fact that PPOs do not bear risk raises serious questions about the actual value they add. Indeed, the program may need a "tune-up," possibly including the addition of diagnosis-based risk adjustment, regional pricing, and a minimum standard for benefit packages.[38]

CONVERTING MEDICARE TO THE FEHBP MODEL

Several policy leaders and experts have advocated converting the Medicare program to a defined contribution approach along the lines of FEHBP.[39] Under their proposals, Medicare beneficiaries would choose among competing private plans, with the federal government providing a fixed dollar amount toward coverage based on a percentage of the average plan premium (e.g., 85%). Beneficiaries would pay the difference between the government contribution and the premium of the plan they selected.

There are a number of variations on this model that raise several important issues. The first is whether basic Medicare fee-for-service coverage would continue as an option. The prescription drug bill passed by the House of Representatives would retain Medicare fee-for-service as an option (although the amount charged in fee-for-service would include indirect medical education, disproportionate share hospital payments, and other

[37] C. Schoen and L. Zacharias, with G. Santa Anna and S. Kelly, "Federal and State Public Employees Health Benefits Programs," in E. Ginzberg (ed.), *Critical Issues in U.S. Health Reform* (Boulder, Colo.: Westview Press, 1994).

[38] A. C. Enthoven, "Employment-Based Health Insurance Is Failing: Now What?" *Health Affairs* Web Exclusive (May 28, 2003): W3-237–W3-249.

[39] For Breaux-Frist I (S. 357—Medicare Preservation and Improvement Act of 2001) and Breaux-Frist II (S. 358—Medicare Prescription Drug and Modernization Act of 2001), see T. Rice and K. A. Desmond, *An Analysis of Reforming Medicare Through a "Premium Support" Program* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, 2002); S. M. Butler and R. E. Moffit, "The FEHBP as a Model for a New Medicare Program," *Health Affairs* 14 (Winter 1995): 47–61; Cain, "Moving Medicare," 1999; H. J. Aaron and R. D. Reischauer, "The Medicare Reform Debate: What Is the Next Step?" *Health Affairs* 14 (Winter 1995): 8–30; Enthoven, "Effective Management," 1989.

social policy costs not included in the amount charged by private plans).[40] Some policy experts, on the other hand, prefer eliminating Medicare fee-for-service as an option entirely. Other legislative proposals would leave fee-for-service largely unchanged, simply applying the FEHBP model to private plans (e.g., Breaux-Frist II).[41] Ironically, the Medicare fee-for-service program could be considered one of the earliest PPOs: it sets a discounted fee schedule, and its enormous purchasing power allows for a broad network of participating hospitals and physicians willing to accept those payment rates.

The second key issue is how the defined government contribution would be established. Some proposals, including the House Medicare prescription drug bill and Breaux-Frist I, base the defined contribution on the average-cost plan (premiums weighted by enrollment). Early policy proposals, on the other hand, envisioned budgetary savings from tying the government contribution to general economic or health cost indicators rather than actual Medicare outlays, which grow at a faster rate.[42] Moon estimated that beneficiary out-of-pocket costs under premium support proposals similar to those advanced by Senators John Breaux and William Frist (as members of the Bipartisan Commission on the Future of Medicare) would consume an average of 30 to 39 percent of beneficiaries' incomes in 2025, compared with a projected 29 percent under current law.[43]

Risk Selection

Private health plans generally have an incentive to avoid sicker, more disabled beneficiaries or to encourage such beneficiaries to disenroll.[44] In fact, competition among plans in Medicare+Choice has been geared more toward discouraging the sickest beneficiaries from enrolling rather than competing on price. Out-of-pocket costs, for example, have increased much more rapidly for those in the poorest health, effectively discouraging sicker beneficiaries from joining or remaining in private plans.[45]

One of the keys to preventing risk selection and reaping the potential benefits of plan competition is effective risk adjustment of premiums. Risk adjustment helps ensure that people do not pay a higher premium because of a concentration of older, sicker enrollees in the health plan they choose. FEHBP currently does not adjust for risk. The

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[40] Health Policy Alternatives, Inc., *Prescription Drug Coverage for Medicare Beneficiaries: A Side-by-Side Comparison of Selected Proposals (Proposed as of July 15, 2001)* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, 2001).

[41] Butler and Moffit, "FEHBP as a Model," 1995; Aaron and Reischauer, "Medicare Reform Debate," 1995; Health Policy Alternatives, *Prescription Drug Coverage,* 2001.

[42] Butler and Moffit, "FEHBP as a Model," 1995; Aaron and Reischauer, "Medicare Reform Debate," 1995.

[43] M. Moon, *Restructuring Medicare: Impacts on Beneficiaries* (New York: The Commonwealth Fund, May 1999).

[44] Moon, *Medicare and Private Plans,* 2003; K. M. Langwell and L. A. Esslinger, *Medicare Managed Care: Evidence on Use, Costs, and Quality of Care* (New York: The Commonwealth Fund, May 1997).

[45] Gold and Achman, *Average Out-of-Pocket,* 2003.

risk adjustment methods used in the Medicare+Choice program, meanwhile, are inadequate to prevent favorable risk selection by participating plans.

Adverse risk selection can manifest itself in a number of ways and is especially troubling when Medicare beneficiaries are involved. One-third of beneficiaries have serious physical or cognitive impairments, which account for two-thirds of Medicare's health care outlays.[46] With skewed expenditures creating a strong incentive for plans to market to younger, healthier enrollees, sicker, frail, and impaired beneficiaries would become concentrated in fee-for-service Medicare. As a result, premiums in that program would spiral upward over time.

It may also be the case that sicker or disabled Medicare beneficiaries prefer to remain in basic fee-for-service coverage because of the broad, unrestricted choice of hospitals and physicians it offers. But whether adverse selection into traditional Medicare results from plans' behavior or beneficiaries' preferences, without a better risk-adjustment mechanism it will certainly lead to higher costs for those people least equipped to bear them, and to competition based on selection rather than efficiency.

Potential Overall Costs

The desirability of converting Medicare to a FEHBP model depends in part on whether private plans have the ability to purchase care as economically as Medicare. As purchaser of health care services for 40 million Medicare beneficiaries, the government is able to obtain more favorable payment rates than private plans from hospitals, physicians, and other health care providers. The Medicare Payment Advisory Commission estimated that in 2002, Medicare paid physicians at 77 to 79 percent the rate paid by private insurers.[47] For large teaching hospitals, Medicare's payment rates are 12 percent lower than those of private insurers.[48]

Administrative costs are lower in Medicare as well. Medicare's administrative costs are 2 percent of claims expenses, compared with 10 to 15 percent for HMOs participating in FEHBP and 7 percent for PPOs in FEHBP.[49] Private plans pay commissions to their sales forces in order to enroll individuals, advertise products, set aside funds for reserves, and set premiums to achieve a profit that is acceptable to stockholders and Wall Street analysts. Medicare incurs none of these costs.

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[46] M. Moon and M. Storeygard, *One-Third at Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems* (New York: The Commonwealth Fund, Sept. 2001).

[47] Medicare Payment Advisory Commission (MedPAC), *Medicare Payment Policy,* Report to Congress (Washington, D.C.: MedPAC, Mar. 2003).

[48] A. Dobson, L. Koenig, N. Sen, S. Ho, and J. Gilani, *Financial Performance of Academic Hospital Center Hospitals, 1994–2000* (New York: The Commonwealth Fund, Sept. 2002).

[49] Merlis, *Federal Employees,* 2003.

As a result of lower administrative costs and lower provider payment rates, Medicare has inherent cost-savings advantages over all private plans. Private plans to date have not demonstrated added value that outweighs these inherent advantages. In principle, private plans could select provider networks based on quality of care and efficiency, provide financial rewards for better management of chronic conditions, review utilization of services, profile physician practices, and incorporate other techniques to generate greater value for the premium dollar. This kind of value-based purchasing is a rarity, however, in the private market.[50] Moreover, nothing restricts Medicare from pursuing these strategies as well; in fact, Medicare has begun testing innovative models for managing chronic conditions and rewarding high-quality care.

Finally, it is important to note that most Medicare beneficiaries are highly satisfied with the current program. Medicare outperforms private sector employer plans in terms of patient satisfaction with quality of care and access to care and overall ratings of insurance.[51] Switching Medicare to a FEHBP model runs the risk of alienating those it is designed to serve.

Government Costs

Despite Medicare's history of lower cost growth, converting the program to a FEHBP-like model could yield greater control over government budgetary costs and potential government savings. This could occur over time if: (a) beneficiaries enroll in more "efficient care" plans; (b) benefits in the "average" plan erode, leading to lower average plan premiums; or (c) the government reduces the percentage of the premium it covers. However, (a) is difficult to achieve without adequate risk adjustment. If (b) and (c) occur, the government would be better protected only because more of the financial burden would be shifted to beneficiaries.

Beneficiaries' Financial Risk

Switching from a defined benefit to a defined contribution would increase the financial risk that beneficiaries would face.[52] First, sicker beneficiaries are more likely to stay in traditional Medicare, causing the "cost" of this option to rise relative to that of private plans. Beneficiaries making this choice would be required to pay an additional premium as

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[50] N. I. Goldfarb, V. Maio, C. Carter, L. Pizzi, and D. B. Nash, *How Does Quality Enter Into Health Insurance Purchasing Decisions?* (New York: The Commonwealth Fund, May 2003); V. Maio, N. I. Goldfarb, C. Carter, and D. B. Nash, *Value-Based Purchasing: A Review of the Literature* (New York: The Commonwealth Fund, May 2003).

[51] K. Davis, C. Schoen, M. Doty, and K. Tenney, "Medicare Versus Private Insurance: Rhetoric and Reality," *Health Affairs* Web Exclusive (Oct. 9, 2002): W311–W324.

[52] M. Moon, *Medicare and Private Plans: Separating Fact from Fiction,* testimony before the Senate Special Committee on Aging, "Competition in a Modernized Medicare: Separating Fact from Fiction," May 6, 2003.

well. Second, as in the Medicare+Choice program,[53] services covered by participating health plans could decline over time or beneficiary cost-sharing could increase—or both—leading to higher enrollee costs. Such a scenario would create particular hardships for sicker, more disabled individuals who require more comprehensive benefits and are heavy users of health care services.

Third, if government budgetary pressures mount as baby boomers retire, the formula for setting the government contribution toward coverage could be modified to increase the beneficiary share of the premium. For example, rather than setting the contribution at 85 percent of the average plan premium (as in Breaux-Frist I), the rate could be lowered to 80 or 75 percent. Early proposals to peg the government's contribution to general economic or health cost indicators were particularly alarming to those concerned that such indices would reduce even further Medicare's share of total beneficiary health outlays.[54]

The government currently pays only 57 percent of total health care expenses (including noncovered services, such as long-term care and prescription drugs).[55] A defined contribution plan could lead to a steady reduction in this percentage over time. Under current law, beneficiaries pay 22 percent of income on their own health care expenses; these are projected to rise to 29 percent in 2025.[56] Shifting more of the financial cost of health care onto beneficiaries would add to their already substantial out-of-pocket costs.

Choices and Complexity

Putting basic fee-for-service Medicare on the same competitive footing as other plans, or eliminating it as a choice entirely, has been suggested by the health insurance industry as a means of enticing more private plans to participate and remain in Medicare. Although such a development might result in a greater number of plan choices and a broader array of provider networks, it would not generate a greater choice of providers, since nearly all now participate in traditional Medicare.

Proponents of using FEHBP as a model for Medicare contend that a system in which beneficiaries enjoy a wide choice of plans but must pay the additional premium for

[53] M. Gold and L. Achman, *Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase 10 Percent in 2003* (New York: The Commonwealth Fund, Aug. 2003).

[54] C. Schoen and B. S. Cooper, *Medicare's Future: Current Picture, Trends, and Prescription Drug Policy Debate* (New York: The Commonwealth Fund, July 2003). Available at http://www.cmwf.org/programs/medfutur/medicarechtpk_debate_659.ppt.

[55] Schoen and Cooper, *Medicare's Future,* 2003.

[56] Moon, *Restructuring Medicare,* 1999.

more expensive plans would make enrollees more sensitive to the different cost of health plan options.[57] Because beneficiaries would have an incentive to select the least costly plan that offers the benefits they need, Medicare spending growth would decline.

Extrapolating the FEHBP experience to Medicare beneficiaries is, however, problematic. For example, studies suggest that retirees are less sensitive to differences in premiums than younger people, are less willing to change doctors, and are less able or willing to learn new insurance rules.[58] And although FEHBP provides federal employees with training sessions to explain options, distributes handbooks, and provides online access to information on plan quality, other employers have found that retirees require substantially greater investments in education about choices than younger workers. To date, neither FEHBP nor Medicare has invested the substantial funds necessary to ensure that 40 million Medicare beneficiaries have the tools required to select the most efficient plan for their particular needs. Indeed, we do not even know how to identify "efficient" plans.

Given their age and general health, Medicare beneficiaries also are riskier to insure than federal employees and have greater difficulty making informed choices. The average Medicare beneficiary is 75 years old, while the average FEHBP employee is not quite 46. One-third of Medicare beneficiaries have serious physical or cognitive impairments.[59] Four million elderly Americans suffer from Alzheimer's disease. Two million Medicare beneficiaries reside in nursing homes. Twelve million beneficiaries have less than a high school education.[60] As the history of Medicare+Choice bears out, great complexity and variability in benefit design undercuts informed choice even for well-educated, healthy individuals.[61]

Plan Stability

Both Medicare+Choice and FEHBP have experienced considerable instability in the participation of private plans.[62] Between 1999 and 2003, 206 plans withdrew from Medicare+Choice, affecting 2.4 million beneficiaries.[63] These withdrawals resulted in less

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[57] Families USA, *Why FEHBP Isn't a Good Option for Medicare* (Washington, D.C.: Families USA, Mar. 2003). Available at http://www.familiesusa.org/site/DocServer/FEHB_Issue_Brief.pdf?docID=316.

[58] Moon, *Medicare and Private Plans,* 2003.

[59] Moon and Storeygard, *One-Third at Risk,* 2001.

[60] K. Davis, *Strengthening Medicare: Modernizing Beneficiary Cost-Sharing,* testimony before the House Ways and Means Committee, May 9, 2001. US Census Bureau, *Educational Attainment: 2000,* August 2003, p. 5.

[61] B. Biles, G. Dallek, and A. Dennington, *Medicare+Choice After Five Years: Lessons for Medicare's Future* (New York: The Commonwealth Fund, Sept. 2002).

[62] J. Stuber, G. Dallek, C. Edwards, K. Maloy, and B. Biles, *Instability and Inequity in Medicare+Choice: The Impact for Medicare Beneficiaries* (New York: The Commonwealth Fund, Jan. 2002).

[63] G. Dallek, B. Biles, and L. H. Nicholas, *Lessons from Medicare+Choice for Medicare Reform* (New York: The Commonwealth Fund, June 2003); Biles, Dallek, and Dennington, *Medicare+Choice After Five Years,* 2002.

geographic coverage, less choice, less generous benefits, and higher premiums. Unstable health coverage can also contribute to lack of continuity in physician relationships, a particularly serious issue for elderly and disabled people. One study found that Medicare beneficiaries who have been with the same physician for 10 years or more have lower costs.[64]

Although the number of plans participating in FEHBP is projected to increase next year, more than 100 plans withdrew from the program between 2000 and 2002.[65] Given that Medicare beneficiaries are a high-risk population, and that unpredictable utilization and excessive risk were major reasons for plan withdrawals from FEHBP, converting Medicare to a FEHBP model is unlikely to yield greater plan stability. Plans may be concerned that they will enroll a large number of ill, high-cost enrollees and that the premiums they set will be insufficient to cover the risk. If the government does not share a substantial portion of this risk, plans that attract a sicker group of enrollees may simply drop out.

If the current FEHBP pricing policy were to prevail, geographic differences would likely present problems as well, since HMOs have local premiums and PPOs have uniform, national premiums. In a national plan such as Blue Cross Blue Shield, for example, premiums are required by law to be the same throughout the country. Local plans, however, may offer premiums that reflect costs in their area. Medicare+Choice local plans are, for the most part, located in high-cost areas, and their location does not always coincide with that of FEHBP local plans. According to an analysis by the Center for Rural Health Policy, FEHBP plans are less likely to locate in areas with a higher number of hospital beds and general physician supply.[66] HMOs under FEHBP will not necessarily be competing in the same areas in which they currently are competing. This is an important point when considering whether to use the FEHBP model for Medicare.

Government Involvement

If basic Medicare were not retained as an option, private plans, not the federal government, would make decisions about covered benefits, provider payment rates, quality standards, and other aspects of administration. In principle, this would remove

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[64] J. Blustein and L. J. Weiss, "Faithful Patients: The Effect of Long-Term Physician–Patient Relationships on the Costs and Use of Healthcare by Older Americans," *American Journal of Public Health* 86 (Dec. 1996) 1742–47.

[65] GAO, *Federal Employees', OPM's Role,* 2002, p. 7.

[66] T. McBride, C. Andrews, K. Mueller, and M Shambaugh-Miller, *Availability and Use of Health Plan Choices in Rural America: Medicare+Choice, Commercial HMO, and Federal Employees Health Benefit Program Plans. Draft* (Omaha, Neb.: RUPRI Center for Rural Health Policy Analysis, May 2003). Available at http://www.rupri.org/healthpolicy/Managed%20Competition%20060603.pdf.

many of the political pressures on Congress to make annual adjustments to Medicare and would permit benefits to change automatically as medical progress occurs. In practice, however, Medicare's sheer size and importance as a purchaser of health care services (the "800-pound gorilla") makes it likely that beneficiary and provider groups would take any dissatisfaction with private plans to Congress. As the experience of Medicare+Choice demonstrates, there would also be pressure from the managed care industry to raise government payment to plans.

COVERING THE UNINSURED UNDER FEHBP

In contrast to Medicare beneficiaries, the uninsured fare least well by nearly every measure of health care satisfaction, access, and quality.[67] Three of four of the uninsured are employed but covered by group health insurance, either because their employer does not offer coverage at all, they are not eligible for their firm's health plan, or they cannot afford their share of the plan's premium.[68] In turn, inadequate access to affordable health insurance is the major reason businesses do not offer coverage to their employees. In a 2003 survey sponsored by the Henry J. Kaiser Family Foundation and the Health Research and Educational Trust, 76 percent of small firms (3–199 workers) said that high premiums are a very important reason why they do not offer health benefits.[69]

When employers do not provide health coverage and workers do not qualify for low-income public programs, the primary alternative is the individual health insurance market. Yet, this market provides poor value for the premium dollar. Individual insurance pays substantially less of the average health care bill than does employer-sponsored group insurance—63 percent versus 75 percent.[70] Moreover, patient cost-sharing is significantly greater for individual policies, which also typically offer fewer benefits than group plans. Covering 16 million Americans, individual policies account for roughly 7 percent of the health coverage of Americans under age 65. Unlike insurance offered by large employers, companies selling individual policies in most states undertake vigorous medical underwriting on each applicant. As a result, those covered by individual health insurance tend to be in good health, or premiums rise rapidly as health deteriorates and plans re-rate policies.

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[67] K. Davis, C. Schoen, S. C. Schoenbaum, A.M. Audet, M. M. Doty, and K. Tenney, *Mirror, Mirror on the Wall: The Quality of American Health Care Through the Patient's Lens* (New York: The Commonwealth Fund, forthcoming).

[68] S. Collins, C. Schoen, D. Colasanto, and D. A. Downey, *On the Edge: Low-Wage Workers and Their Health Insurance Coverage* (New York: The Commonwealth Fund, Apr. 2003).

[69] Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2003 Annual Survey* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, 2003).

[70] J. Gabel, K. Dhont, H. Whitmore, and J. Pickreign, "Individual Insurance: How Much Financial Protection Does It Provide?" *Health Affairs* Web Exclusive (Apr. 17, 2002): W172–W181.

Many Americans who have sought coverage in the individual insurance market simply give up. Only about one-fourth of those seeking coverage actually purchase it, largely because the premiums are too expensive, benefits are too limited, or their prior health problems make them ineligible.[71] Women are particularly at a disadvantage in the individual market.[72] Older adults as well are unlikely to find individual coverage at an affordable rate.[73]

Opening up FEHBP, with its lower administrative costs and large group pooling, could result in lower premiums than small businesses or individuals can now obtain on their own. Even so, some form of premium assistance or tax credit is likely to be required to make plans under FEHBP affordable for low-income, uninsured individuals.[74] Establishing a separate financing pool would help ensure that premiums for federal employees are not affected by the cost of extending coverage to nonfederal employees. In addition, a variety of measures is needed to guard against a selection-induced "death spiral."[75] Incorporation of federally subsidized reinsurance or stop-loss provisions, along with risk adjustment, could help mitigate the effect on premiums of any adverse risk selection.[76]

One study explored the potential of establishing a Congressional Health Plan for small businesses with fewer than 50 employees and uninsured individuals who had been without coverage for at least six months.[77] This expansion would start with FEHBP as a base but would have a separate financing pool to avoid affecting premiums of federal employees. All private plans participating in FEHBP would be required to participate in the Congressional Health Plan. Estimated premiums for 2002 were $2,880 for individuals and $8,328 for family coverage. A reinsurance pool was proposed to hold these premiums to expected average community rates. Premiums would be made affordable for individuals through tax credits that would cover 90 percent of premiums of Blue Cross Blue Shield's FEHBP standard-option benefit package in excess of 5 percent of income for individuals in lower tax brackets (10 percent for those in higher tax brackets). Under the proposal,

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[71] L. Duchon and C. Schoen, *Experiences of Working-Age Adults in the Individual Insurance Market* (New York: The Commonwealth Fund, Dec. 2001).

[72] S. R. Collins, S. B. Berkson, and D. A. Downey, *Health Insurance Tax Credits: Will They Work for Women?* (New York: The Commonwealth Fund, Dec. 2002).

[73] E. Simantov, C. Schoen, and S. Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs* 20 (July/Aug. 2001): 139–49.

[74] B. Fuchs, *Increasing Health Insurance Coverage Through an Extended Federal Employees Health Benefits Program* (New York: The Commonwealth Fund, Dec. 2000); Collins, Berkson, and Downey, *Health Insurance Tax Credits,* 2002.

[75] M. Merlis, *Opening the Federal Employees Health Benefits Program to Individual Purchasers*. Unpublished. July 2001.

[76] K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," *Health Affairs* Web Exclusive (Apr. 23, 2003): W3-199–W3-211.

[77] Davis and Schoen, "Creating Consensus," 2003.

uninsured individuals would be identified through insurance verification and automatically enrolled in the Congressional Health Plan. The study estimated that 24 million people would be covered under the Congressional Health Plan, including 10 million people who would switch coverage from the small business or individual market to take advantage of the lower premiums available through large group insurance. High-risk older adults and the disabled would be covered under Medicare, while those with incomes below 150 percent of poverty would be eligible for coverage under an expansion of the State Children's Health Insurance Program.

Three of the Democratic presidential candidates—General Wesley Clark, Governor Howard Dean, and Senator John Kerry—have incorporated provisions similar to the Congressional Health Plan in their universal health insurance proposals.[78] They follow in the footsteps of policy officials across a wide political spectrum who have proposed opening up FEHBP to small businesses and uninsured individuals. Former Senator William Roth (R-Del.) introduced S. 1978, the Federal Health Care Expansion Act of 1994, which would have phased-in coverage of small employer groups under FEHBP.[79] Former Senator Bill Bradley (D-N.J.) proposed covering under FEHBP everyone under age 65 who was not enrolled in an employer plan. Representative Pete Stark (D-Calif.) introduced H.R. 2185, the Health Insurance for All Americans Act of 1999, to expand health insurance coverage using FEHBP, with tax credits to make premiums more affordable.[80]

The likely consequences of creating a new program of group insurance modeled on FEHBP for small business and uninsured individuals depend on specific provisions and on how closely it would resemble FEHBP.

Costs and Access

FEHBP has lower administrative overhead than the individual and small business market, where overhead can run 20 to 50 percent.[81] The large group pooling in FEHBP could result in lower premiums for small businesses or individuals seeking coverage on their own; it could also provide access to individuals turned away by the individual market. As with opening up FEHBP to Medicare beneficiaries, however, there is a major concern that only sicker uninsured individuals and higher-risk small businesses would opt for coverage through FEHBP plans. Reinsurance or stop-loss provisions would be required to

[78] Collins, Davis, and Lambrew, *Health Care Reform Returns,* 2003.
[79] Fuchs, *Increasing Health Insurance,* 2000.
[80] Fuchs, Increasing Health Insurance, 2000.
[81] Congressional Research Service, *Health Insurance and the Uninsured. Background Data and Analysis* (Washington, D.C.: U.S. GPO, 1988).

reduce adverse risk selection. In addition, implementation would need to proceed cautiously to gauge the extent of plan stability and risk selection over time.

Plan Choices

With a large group purchasing pool, FEHBP would also provide a wide choice of plans. When small businesses offer coverage, most offer only one plan, often with limited benefits and a restricted network of providers that are not convenient for all employees. Because of potential reluctance to increase the share of business subject to government intervention, however, some FEHBP plans may not be supportive of expanding enrollment to additional populations.

Administrative Complexity

FEHBP would operate differently for small businesses than it would for federal employees. For example, FEHBP, with its exclusively federal enrollment, can automatically deduct employees' and retirees' premium shares from paychecks or pension checks. Administering a plan for 8.5 million geographically concentrated federal employees and retirees is far less complex than doing so for 44 million uninsured people living throughout the country. Sheer size alone would require hiring personnel, opening up new offices, and mounting other administrative operations. Electronic enrollment might be feasible for some individuals but is unlikely to be an option for most of the working uninsured, at least initially. Most small businesses would want someone locally who could explain plan choices, premiums, and benefits to employees and answer problems with payment of claims.

Opening up FEHBP would allow workers in small firms to stay in the same health plan when they moved from one small employer to another, or became unemployed. However, there is considerably more turnover of employment and insurance coverage among the 44 million uninsured than among the federal workforce, and so there would be a greater administrative burden. The program would be required to track frequent changes in work status of the party responsible for the premiums, changes in the share of the premiums paid by each party, changes in employee addresses, and similar dislocations.

CONCLUSION

The primary challenge facing a system of competing private plans is the stability of plan participation and experience with adverse risk selection. If plans succeed in attracting relatively healthy enrollees, their premiums will be lower not because they are more efficient, better managers of care, or because they attract a higher-performing network of health care providers, but because they avoid high-cost patients. The issue of risk selection is also central to how well FEHBP-like coverage would work if extended to Medicare

beneficiaries, small businesses, or the uninsured. The potential for risk selection and the effectiveness of mechanisms for minimizing this concern largely shape how workable the FEHBP model would be when applied to new types of enrollees.

The attractiveness of FEHBP as a model for Medicare, the uninsured, or all Americans hinges in large part on whether it is an improvement over current sources of coverage. For the uninsured and small businesses, it has marked advantages—the promise of better premiums, better benefits, more choice, and greater stability of coverage. Opening up FEHBP to these groups, however, would need to proceed slowly. Reinsurance or stop-loss provisions would be needed, and plan stability and risk selection over the long term would need to be assessed. An automatic enrollment feature and adequate premium assistance are likely to be key in ensuring sufficient enrollment of healthier individuals to stabilize the program.

For Medicare beneficiaries, conversion to a FEHBP-like model poses serious risks. The enrollment of very sick and very disabled beneficiaries in private plans would likely intensify the already significant risk selection problems evidenced in Medicare+Choice and FEHBP. Further, FEHBP has higher administrative costs than Medicare, and private plans pay providers higher rates than traditional fee-for-service Medicare. The disappointing record of Medicare+Choice—its unstable plan participation, erosion in benefits, rising premiums, provider withdrawals from plan networks, and complex benefit design—strongly suggest that converting to the new model is an enterprise fraught with danger.[82] It is likely to cost, not save, the government money and could markedly increase the financial risk that Medicare beneficiaries face.

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[82] Dallek, Biles, and Nicholas, *Lessons from Medicare+Choice,* 2003; Biles, Dallek, and Dennington, *Medicare+Choice After Five Years,* 2002.

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#657 *Creating Consensus on Coverage Choices* (April 23, 2003). Karen Davis and Cathy Schoen, The Commonwealth Fund. *Health Affairs* Web Exclusive. In this article, the authors propose an innovative framework to provide automatic, affordable health insurance to nearly all Americans. The approach would combine tax credits for private insurance with public program expansions. It would also promote insurance efficiencies through automatic enrollment, use of information technology, and group coverage. The framework could be phased in over time and modified along the way. Available online at http://www.healthaffairs.org/WebExclusives/2203Davis.pdf/.

#622 *Time for Change: The Hidden Cost of a Fragmented Health Insurance System* (March 2003). Karen Davis, The Commonwealth Fund. In invited testimony before the Senate Special Committee on Aging, Fund president Karen Davis detailed the failure of the U.S. health care system to meet the objectives of ensuring access to needed medical care and protecting Americans from the financial burden of costly medical bills. Calling the system "costly, complex, and confusing," Davis said the solution requires automatic and affordable health insurance coverage for all Americans and shared responsibility for financing coverage.

#596 *Expanding Health Insurance Coverage: Creative State Solutions for Challenging Times* (January 2003). Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, Economic and Social Research Institute. The authors summarize lessons from 10 states that have innovative strategies in place for health insurance expansion or have a history of successful coverage expansion. The report concludes with recommendations for federal action that could help states

maintain any gains in coverage made and possibly extend coverage to currently uninsured populations.

#585 *Small But Significant Steps to Help the Uninsured* (January 2003). Jeanne M. Lambrew and Arthur Garson, Jr. A number of low-cost policies could ensure health coverage for at least some Americans who currently lack access to affordable insurance, this report finds. Included among the dozen proposals outlined is one that would make COBRA continuation coverage available to all workers who lose their job, including employees of small businesses that are not currently eligible under federal rules.

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#512 *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk* (December 2001). Lisa Duchon, Cathy Schoen, Michelle M. Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman. This report, based on The Commonwealth Fund 2001 Health Insurance Survey, finds that in the past year one of four Americans ages 19 to 64—some 38 million adults—was uninsured for all or part of the time. Lapses in coverage often restrict people's access to medical care, cause problems in paying medical bills, and even make it difficult to afford basic living costs such as food and rent.

#478 *Universal Coverage in the United States: Lessons from Experience of the 20th Century* (December 2001). Karen Davis. This issue brief, adapted from an article in the March 2001 *Journal of Urban Health: Bulletin of the New York Academy of Medicine,* traces how the current U.S. health care system came to be, how various proposals for universal health coverage gained and lost political support, and what the pros and cons are of existing alternatives for expanding coverage.

#415 *Challenges and Options for Increasing the Number of Americans with Health Insurance* (January 2001). Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University. This overview paper summarizes the 10 option papers written as part of the series Strategies to Expand Health Insurance for Working Americans.

#438 *A 2020 Vision for American Health Care* (December 11/25, 2000). Karen Davis, Cathy Schoen, and Stephen Schoenbaum. *Archives of Internal Medicine,* vol. 160, no. 22. The problem of nearly 43 million Americans without health insurance could be virtually eliminated in a single generation through a health plan based on universal, automatic coverage that allows choice of plan and provider. The proposal could be paid for, according to Fund President Davis and coauthors, by using the quarter of the federal budget surplus which results from savings in Medicare and Medicaid.

#414 *Increasing Health Insurance Coverage Through an Extended Federal Employees Health Benefits Program* (December 2000). Beth C. Fuchs, Health Policy Alternatives, Inc. The FEHBP has often been proposed as a possible base to build on for group coverage. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes an extension of FEHBP (E-FEHBP) that would operate in parallel with the existing program. The proposal would require anyone qualifying for a tax credit to obtain it through E-FEHBP and would also permit employees of small firms (<10 workers) to purchase health insurance through the program.